

**THIS MDR TRACKING NO. WAS WITHDRAWN.
THE AMENDED MDR TRACKING NO. IS: M5-04-3460-01**

MDR Tracking Number: M5-04-1023-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-08-03.

The IRO reviewed electrical stimulation, unlisted modality-acupuncture, office visit with evaluation, office visits rendered from 12-10-02 through 05-06-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 02-25-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
12-10-02 through 5-6-03 (3 DOS)	99213	\$144.00 (1 unit @ \$48.00 X 3 DOS)	\$0.00	F	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information for DOS 12-10-02 and 5-6-03. Requestor did not submit relevant information for DOS 12-17-02. Reimbursement recommended in the amount of \$48.00 X 2 DOS = \$96.00
12-16-02 through 4-29-03 (3 DOS)	97032	\$198.00 (3 units @ \$66.00)	\$0.00	F	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information for DOS 12-16-02 and 12-24-02. Requestor did not

		X 3 DOS)					submit relevant information for DOS 4- 29-03. Reimbursement recommended in the amount of \$66.00 (3 units) X 2 DOS = \$132.00
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
12-17-02 through 2- 28-03 (5 DOS)	97032	\$330.00 (3 units @ \$66.00 X 5 DOS)	\$0.00	NO EOB	\$22.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information for DOS 1-14-03, 2-4-03, 2-11-03 and 2-28-03. Requestor did not submit relevant information for DOS 12-17-02. Reimbursement recommended in the amount of \$66.00 (3 units) X 4 DOS = \$264.00
12-16-02 through 4- 22-03 (9 DOS)	97139- AC	\$720.00 (2 units @ \$96.00 X 8 DOS, 1 unit @ 48.00 X 1 DOS)	\$0.00	F	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$96.00 X 8 DOS and \$48.00 X 1 DOS = \$720.00
12-17-02 through 2- 28-03 (5 DOS)	97139- AC	\$480.00 (2 units @ \$96.00 X 5 DOS)	\$0.00	NO EOB	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to meet documentation criteria. Reimbursement recommended in the amount of \$96.00 (2 units) X 5 DOS = \$480.00
12-16-02	99215	\$309.00	\$0.00	NO EOB, F	\$103.00	Rule 133.307	Requestor

through 3-25-03 (3 DOS)		(1 unit @ \$103.00 X 3 DOS)		DOS 12-16-02, 12-24-02 and 3-25-03 denied NO EOB DOS 12-24-02 denied F code		(g)(3)(A-F)	submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$103.00 X 3 DOS = \$309.00
1-14-03 through 4-8-03 (5 DOS)	99213	\$240.00 (1 unit @ \$48.00 X 5 DOS)	\$0.00	NO EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$48.00 X 5 DOS = \$240.00
4-29-03	97139-AC	\$96.00 (2 units)	\$0.00	N	DOP	96 MFG MEDICINE GR (I)(9)(b)	Requestor did not submit relevant information to meet documentation criteria. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
TOTAL		\$2,517.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$2,241.00

This Decision is hereby issued this 11th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 12-10-02 through 05-06-03 in this dispute.

This Order is hereby issued this 11th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

February 23, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1023-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 35 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell from a scaffold approximately 12 feet in the air. The patient was evaluated in the emergency room where he underwent a CT scan that was reported as normal and was released the same day. The patient began a physical therapy rehabilitation program for treatment of neck pain, headache, vertigo, and low back pain.

The patient underwent a head MRI on 10/16/01 that was reported as normal and an EEG. From 5/1/02 through 5/22/02 the patient underwent neuropsychiatric testing that indicated conversion disorder with mixed presentation, recurrent moderate major depressive disorder, rule out cognitive disorder, and borderline intellectual functioning. The diagnoses for this patient have included closed head injury, post concussion syndrome, conversion disorder, lumbar and cervical strain. The patient was also diagnosed with global aphasia for approximately six months after the injury. Treatment for this patient's condition has included physical therapy, medications, and psychotherapy. The patient has also undergone Electro-Auricular Acupuncture for treatment of symptoms related to his closed head injury.

Requested Services

Electrical Stimulation, unlisted modality-acupuncture, office visit evaluation (40 min), office visits evaluation (15 min) from 12/10/02 through 5/6/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ____ physician reviewer noted that this patient concerns a 35 year-old male who sustained a work related injury to his neck, head, and low back. The ____ physician reviewer indicated that the patient was diagnosed with a mild closed head injury, and neck and back strains. The ____ physician reviewer noted that the patient complained of symptoms that included vertigo, aphasia and pain. The ____ physician reviewer also noted that the patient underwent a MRI of the brain and neck, and an EEG. The ____ physician reviewer explained that the neurological testing results were consistent with conversion disorder. However, the ____ physician reviewer further explained that as of late 2002, neurological and physiatry evaluations revealed no significant diagnoses for this patient. Therefore, the ____ physician consultant concluded that the electrical stimulation, unlisted modality-acupuncture, office visit evaluation (40 min), office visits evaluation (15 min) from 12/10/02 through 5/6/03 were not medically necessary.

Sincerely,